of Tennessee

PPO Limited

State of Tennessee

- Member Handbook
- Blue Network P Provider Directory

2007

Important Notice

This member handbook explains many features of the PPO-Limited health care option. It describes your benefits in general terms and is not intended to give all the details of every benefit, limitation, or exclusion. The Plan Document is the official legal publication that defines benefits. A copy is available for your review from your insurance preparer or from the State of Tennessee Division of Insurance Administrations web site at www.state.tn.us/finance/ins/.

For services to be covered, they must be determined to be medically necessary.

If you are unsure about whether a procedure, type of facility, equipment, or any other expense is covered, ask your physician to submit a pre-determination request form to the claims administrator describing the condition and planned treatment. Pre-determination requests typically take up to three weeks to review.

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Welcome

Thank you for considering the PPO-Limited plan administered by BlueCross BlueShield of Tennessee. Founded more than a half-century ago, BlueCross BlueShield of Tennessee is the state's leader in health care financing. Today, more than two million Tennesseans turn to our company for health plan coverage, insurance products, and services that help protect their health – and their financial security. Health care coverage is an investment in personal and financial health and security. That's why today's business at BlueCross BlueShield of Tennessee is about financing affordable health care coverage so that you and your family can benefit from the company's real purpose: to provide you peace of mind.

Plan Administration and Claims Administration

The Division of Insurance Administration of the Department of Finance and Administration is the plan administrator and BlueCross BlueShield of Tennessee is the claims administrator. This program is administered using the benefit structure established by the Insurance Committee that governs the plan. When claims are paid under this plan, they are paid from a fund consisting of your premiums and the employer's contributions (if applicable) and not by an insurance company. BlueCross BlueShield of Tennessee is contracted by the state to process claims, establish and maintain adequate provider networks, and conduct utilization management reviews.

Claims paid in error for any reason will be recovered from the employee. Filing false or altered claim forms constitutes fraud and is subject to criminal prosecution. You may report possible fraud at any time by leaving a recorded message with the BlueCross BlueShield Special Investigations Unit or by contacting the Division of Insurance Administration.

Eligibility and Enrollment Topics

Please refer to your Insurance Handbook, available from your insurance preparer, for all information related to eligibility and enrollment. Eligibility and enrollment are managed by the plan administrator.

Member Service

For information about specific health care claims, please call member service. Our representatives are familiar with your specific coverage and are available to answer your questions. When contacting member service, you will be asked to verify your identity and give information from your identification card.

Member Service: 1-800-558-6213, 8 a.m. – 5 p.m. (EST) M-F
Report Fraud: 1-800-496-9600
BlueCard Providers: 1-800-810-2583
Pharmacy Orders: 1-877-683-6837
Transplant Coordinator: 1-888-207-2421
24/7 Nurseline: 1-866-904-7477
Precious Cargo: 1-800-395-BABY

Mailing address for claims:
P O Box 180150
Chattanooga, TN 37401

Mailing address for pre-determination requests, unique and continuous care exception requests:
801 Pine Street
Chattanooga, TN 37402

Web Site

In addition to our standard web site at www.bcbst.com, members can access benefit and provider information with a web page specifically designed for state group insurance program participants. Point your web browser to www.bcbst.com/members/tn_state/ to search for providers, view pharmacy information, and access other helpful information. Several networks are listed, so be sure to look for "Blue Network P."

Members may also use BlueAccess, the secure area of bcbst.com, to view your information in a secure environment using member self-service with a user ID and password. With your BlueAccess ID and password you can:

- Verify benefits, including eligibility and coverage details
- Check medical claim status (excludes prescription drug claims)
- Look up prior authorization status
- View and print an online EOB
- Update your coordination of benefits (COB) information if you have other insurance coverage
- Order ID cards

Mental Health and Substance Abuse

Mental health and substance abuse benefits are administered separately from your medical benefits. Please contact Magellan Health Services at 1-800-308-4934 for assistance in this area. See your agency insurance preparer for detailed benefit information.

Medical Benefits at a Glance

	In-Network	Out-of-Network
DEDUCTIBLES		
Individual maximum per plan year	$500	$500
Family maximum per plan year	$1,500	$1,500
ANNUAL OUT-OF-POCKET MAXIMUM		
Individual maximum per plan year	$5,500	$16,500
Family maximum per plan year	$11,500	$33,000
INPATIENT SERVICES		
Physician services	80% of MAC	60% of MAC
Hospital services (includes semi-private room and board, operating room, intensive care, x-ray, laboratory, drugs, supplies and physician services)	80% of MAC	60% of MAC
OUTPATIENT SERVICES		
General or routine office visit	80% of MAC	60% of MAC
Specialist office visit	80% of MAC	60% of MAC
X-ray, lab and diagnostics	80% of MAC	60% of MAC
Allergy injection	80% of MAC	60% of MAC
Home health care	80% of MAC	60% of MAC
Home infusion therapy	80% of MAC	60% of MAC
Surgical services – physician	80% of MAC	60% of MAC
Surgical services – facility	80% of MAC	60% of MAC
Chiropractors	80% of MAC	60% of MAC
PREVENTATIVE HEALTH/WELL CARE		
Well child checkup and immunizations	80% of MAC	60%of MAC
Annual physical exam – Adult	80% of MAC	60% of MAC
Family planning	80% of MAC	60% of MAC
Annual hearing and vision screening (see covered medical expenses)	80% of MAC	60% of MAC
MATERNITY CARE		
Physician care	80% of MAC	60% of MAC
Hospital care	80% of MAC	60% of MAC
Midwives (in a licensed healthcare facility)	80% of reasonable charges	
REHABILITATION AND THERAPY SERVICES		
Inpatient services	80% of MAC	60% of MAC
Outpatient services (subject to plan limits)	80% of MAC	60% of MAC
Skilled nursing facility (100 day limit following approved hospitalization)	80% of MAC	60% of MAC

	In-Network	Out-of-Network
EMERGENCY CARE (see page 16 for definition/guidelines)		
Emergency room services	$50 copay; 80% of MAC	$50 copay; 60% of MAC
URGENT CARE		
Received at a walk-in clinic	80% of MAC	60% of MAC
Received at a hospital emergency room	$25 copay; 80% of MAC	$25 copay; 60% of MAC
TRANSPORTATION		
Ambulance services (air and ground)	80% of reasonable charges	
If approved for out-of-state exception	80% of reasonable charges	
If approved for transplant	100% subject to applicable limit	None
APPLIANCES AND EQUIPMENT		
Durable medical equipment	80% of MAC	60% of MAC
Supplies (ostomy, bandages, dressings, diabetic)	80% of MAC	60% of MAC
HOSPICE CARE		
Through an approved program	100% of MAC (regardless if deductible has been met)	
PRESCRIPTION DRUGS		
Generic	0% coinsurance	
Preferred	20% coinsurance	
Non-Preferred	40% coinsurance	
Extended prescriptions available for one coinsurance amount through the home delivery program and certain participating mail-at-retail pharmacies	Prescription claims filed by the covered person will be reimbursed based on the MAC less the applicable coinsurance	
DENTISTS		
Extraction of impacted wisdom teeth, excision of solid based oral tumors, accidental injury, orthodontic treatment for correction of facial hemiatrophy or congenital birth defect (subject to plan limits)	80% of reasonable charges	

MAC=Maximum Allowable Charge

Copays represent cost to participant, percentages represent portion paid by the plan.

Covered persons will be responsible for payment of charges above the MAC if non-PPO providers are used.

If preauthorization is required but not obtained, benefits will be reduced to 50% of MAC for out-of-network providers. No benefits will be paid for network providers.

Covered Medical Expenses

1. Office visits to a physician or a specialist due to an injury or illness.
2. Family planning and infertility services including history, physical examination, laboratory tests, advice, and medical supervision related to family planning, medically indicated genetic testing and counseling, sterilization procedures, infertility testing, and treatment for organic impotence. If fertility services are initiated (including, but not limited to, artificial insemination and in-vitro fertilization), benefits will cease.
3. Nutritional guidance when medically appropriate as determined by the claims administrator.
4. Adult preventive care including one routine physical exam per plan year (age 18+), bone density scans (female age 50+ once per year or 65+ as medically necessary), routine women's health exam including breast exam, Pap smear for cervical cancer screening and pelvic exam (age 18+), cholesterol screening (age 40+) every five years or more often if medically necessary, and immunizations (tetanus, measles, mumps, rubella, pneumococcal, influenza, hepatitis B).
5. Well child visits to physicians including checkups and immunizations, 12 visits combined through age 5. Annual checkups for ages 6-17 and immunizations as recommended by the Centers for Disease Control and Prevention (CDC).
6. Mammogram screenings within the following guidelines: Once as a baseline mammogram between ages 35-39; once every year for ages 40 and over; or when prescribed by a physician and determined to be medically necessary.
7. Prostate screening annually for men who have been treated for prostate cancer with radiation, surgery, or chemotherapy and for men over the age of 45 who have enlarged prostates as determined by rectal examination. This annual testing is also covered for men of any age with prostate nodules or other irregularity noted upon rectal exam. The PSA test will be covered as the primary screening tool of men over age 50 and transrectal ultrasound will be covered in these individuals found to have elevated PSA levels.
8. Hospital room and board and general nursing care in a semi-private room or in a specialty care unit if pre-authorized.
9. Charges for medically necessary surgical procedures and administration of anesthesia.
10. Charges for diagnostic laboratory and x-ray services.
11. An approved hospice program that is designed to provide the terminally ill patient with more dignified, comfortable, and less costly care during the six months before death.
12. Durable medical equipment (DME), consistent with a patient's diagnosis, recognized as therapeutically effective and prescribed by a physician and not meant to serve as a comfort or convenience item. Benefits are provided for either rental or purchase of equipment.
13. Removal of impacted wisdom teeth, excision of solid-based oral tumors, and treatment of accidental injury (other than by eating or chewing) to sound natural teeth.
14. Continuous passive motion machine for knee replacement surgery or anterior cruciate ligament repair for 28 days after surgery.
15. The initial purchase of an artificial limb (prosthetic device) necessary due to an illness or injury and subsequent purchases due to physical growth for a covered dependent through age 18. One additional limb prosthesis past age 18 will be covered if additional surgery has altered the size or shape of the stump, or if a severe medical condition could result from improper fitting of the initial prosthesis. Replacement prosthetic due to normal wear and tear or physical development, with written approval.
16. Smoking cessation aids requiring a prescription with a limit of one 90-day period per year and two 90-day periods per lifetime.
17. Expenses for temporomandibular joint malfunctions (TMJ) including history, exams, and office visits; x-rays of the joint, diagnostic study casts; appliances (removable or fixed); physical medicine procedures such as surgery; and medications.
18. Medically necessary services performed by a registered/licensed physical, occupational, or speech therapist. Physical and occupational therapy services are limited to a maximum of 45 visits per condition, per plan year. Speech therapy services to restore speech after a loss or impairment are available as long as there is continued medical progress.

19. The first contact lenses or glasses (excluding tinting and scratch resistant coating) purchased after cataract surgery.
20. Multiple pairs of rigid contact lenses that are determined to be medially necessary by the claims administrator and prescribed only for the treatment of diagnosed keratoconus. Intrastromal Corneal Ring Segments (ICRS) for vision correction are also covered with a diagnosis of keratoconus when certain medical appropriateness criteria are met.
21. Cosmetic surgery only when in connection with treatment of a congenital anomaly that severely impairs the function of a bodily organ or due to a traumatic injury or illness; or reconstructive breast surgery if needed following a covered mastectomy (but not a lumpectomy), as well as surgery to the non-diseased breast to establish symmetry.
22. Diabetes outpatient self-management training and educational services including medical nutrition counseling when prescribed by a physician and determined to be medically necessary with a diagnosis of diabetes, limited to $500 per calendar year. Coverage for additional training and education is available when determined to be medically necessary by the claims administrator.
23. Insulin, the related syringes (including needle-free syringes when medically necessary as determined by the claims administrator based on the patient's age, weight, skin, and medical condition, and/or the frequency of injections), home blood glucose monitors, and related supplies for the treatment of diabetes as approved by a physician.
24. Screenings of the eyes (not including refractive services and supplies) and hearing impairment screening and testing for the purpose of determining appropriate treatment of hearing loss when medically necessary. Availability of benefits limited to once per plan year.
25. Certain organ and bone marrow transplant medical expenses and services (preauthorization required). Hotel and meal expenses will be paid at $150 per diem. The transplant recipient and one other person (guardian, spouse, or other caregiver) are covered. The maximum combined benefit for travel and lodging is $15,000 per transplant.
26. Orthopedic items, when medically necessary as determined by the claims administrator. These items include, but are not limited to, splints, crutches, surgical collars, lumbosacral supports, corsets-back and special surgical, trusses, and rigid back or leg braces.
27. Foot orthotics, including therapeutic shoes, if an integral part of a leg brace, depth or custom-molded, including inserts for those with diabetes mellitus and certain related complications, rehabilitative when part of post-surgical or post-traumatic casting care, prosthetic shoes that are an integral part of the prosthesis, and ankle orthotics, ankle-foot orthoses, and knee-ankle-foot orthoses. Such items will be covered when prescribed by a physician if medically necessary as determined by the claims administrator.
28. Home health care when certified and approved as medically necessary by the claims administrator. When ordered by a physician, covered services are limited to intermittent skilled nursing care given or supervised by a registered nurse including up to 30 home health aide visits.
29. Medically necessary ground and air ambulance services to and from the nearest general hospital or specialty hospital.
30. Blood plasma or whole blood (including components and derivatives) unless donated or replaced by you or a family member.
31. Ketogenic diet counseling when approved through case management.
32. Medically appropriate sleep studies and evaluations.
33. Charges, including procedure charges, physician charges, and facility charges, for certain PET scans when determined to be medically necessary and approved by the claims administrator. (Members or physicians should verify medical necessity and benefit eligibility before incurring charges for use of the PET scan technology.)
34. Some surgical weight reduction programs.
35. Colorectal screenings. Beginning at age 50, men and women have one of the following five screening options available: (1) yearly fecal occult blood test (FOBT), (2) flexible sigmoidoscopy every five years, (3) yearly fecal occult blood test and flexible sigmoidoscopy every five years (preferred over either test alone), (4) double contrast barium enema every five years, or (5) colonoscopy every five years. For individuals determined by their physician to be at high risk for colorectal cancer due to medical or family history, screening may need to begin at an earlier age and occur more frequently.
36. Tubal ligation and vasectomy.
37. Routine patient costs related to clinical trials as defined by TCA 56-7-2365.

Excluded Services and Procedures

1. Services provided by a participant's immediate family member, whether by blood, marriage, or adoption.
2. Services not ordered or furnished by an eligible provider.
3. Charges in excess of the maximum allowable charge when using out-of-network providers.
4. Experimental or investigational treatments, procedures, facilities, equipment, drugs, or supplies as initially determined by the claims administrator to not yet be recognized as acceptable medical practice or which require, but have not received, approval by a federal or other governmental agency. (Members are held harmless for charges or services from network providers **unless** they have signed a waiver accepting responsibility for the cost.)
5. Charges that would be considered a covered injury paid under workers' compensation, regardless of the presence or absence of workers' compensation coverage.
6. Comfort or convenience items.
7. Humidifiers, dehumidifiers, exercise devices, blood pressure kits, heating pads, sun or heat lamps.
8. Podiatric items such as inner soles, corn plasters, foot padding, arch supports, routine foot care, or orthopedic shoes for correction of a deformity or abnormality of the musculoskeletal system unless one or both are attached to a brace. Charges for removal of corns or calluses, or trimming of toenails, with the exception of a diagnosis of diabetes.
9. Hearing aids, including examinations and fittings.
10. Midwife services outside a licensed health care facility.
11. Nonsurgical service for weight control or reduction, including prescription medication.
12. Artificial or nonhuman organ transplants and related services, except for Ventricular Assist Devices (VAD) and Total Artificial Hearts (TAH) when determined to be medically necessary by the claims administrator.
13. Radial keratotomy, LASIK, or other procedures to correct refractive errors; eyeglasses, sunglasses, or contacts including examinations and fitting charges.
14. Surgery or treatment for, or related to, psychogenic sexual dysfunction or transformation.
15. Services or supplies in connection with artificial insemination, in-vitro fertilization, or any procedure intended to create a pregnancy.
16. Wigs.
17. Ear or body piercing.
18. Custodial care, unapproved sitters, day and evening care centers (primarily for rest or for the elderly), or diapers.
19. Programs considered primarily educational and materials such as books or tapes.
20. Extraneous fees such as postage, shipping or mailing fees, service tax, stat charges, or collection and handling fees. Charges for telephone consultations.
21. Over-the-counter medications and supplies (except injectable B-12 for pernicious anemia).
22. Hotel charges unless pre-approved through the organ transplant program.
23. Cosmetic surgery and related expenses including, but not limited to, scar revision, rhinoplasty, and saline injection of varicose veins.
24. Any dental care, treatment, or oral surgery relating to the teeth and gums including, but not limited to, dental appliances, dental prostheses (such as crowns, bridges, or dentures), implants, orthodontic care, fillings, extractions, endodontic care, treatment of caries, gingivitis, or periodontal disease.
25. Treatment and therapies for maintenance purposes.
26. Reversal of sterilization procedures.
27. Charges for prescriptions that are lost, stolen, misplaced, or forgotten.
28. Charges incurred outside the United States unless traveling for business or pleasure.
29. Charges for bathroom chairs, stools, and tub handrails.
30. Fitness clubs and programs.

How the Plan Works

Choice of Doctors

This plan does not require you to choose a primary care physician or PCP nor is there a required referral process for specialist services. The network is made up of physicians, hospitals, and other health care providers who have contracted with us to provide discounts to plan participants. In order to receive maximum benefits, you must use network providers.

Members sometime have a need to see a specialist for a medical condition. Simply chose a specialist that participates in the network and schedule an appointment. If a specialist determines that you should be admitted to the hospital or need services that require prior authorization, they will handle these plan requirements for you. However, it is a good idea to contact us to confirm benefits for hospital admissions or other services that require prior authorization.

OB/GYN Services

Once during each calendar year, you can receive a routine OB/GYN well-woman exam. The yearly well-woman examination is limited to one breast exam, Pap smear and pelvic exam within the calendar year.

Plan Deductible

An annual deductible applies to all eligible medical expenses. After the deductible has been met each year, the plan pays a certain percentage of eligible expenses and you are responsible for the balance. Generally, benefits are 80 percent of the maximum allowable charge when using network providers and 60 percent for out-of-network providers. The annual deductible can be met with a combination of eligible medical expenses with the exclusion of emergency room and pharmacy coinsurance amounts. Ineligible expenses, including amounts that exceed the maximum allowable charge, are not applied to the deductible.

Out-of-Pocket Maximums

After an individual participant has paid $5,500 in eligible medical in-network expenses or $16,500 in eligible out-of-network expenses in a calendar year, the plan will pay 100 percent of eligible expenses, up to the maximum allowable charge for the rest of the calendar year. This is called an out-of-pocket stop loss provision. Your medical deductible amount and emergency room copayments apply toward this out-of-pocket maximum. Charges in excess of the maximum allowable charge, non-covered expenses, prescription drug coinsurance, and mental health and substance abuse treatment do not count toward the medical out-of-pocket maximum.

When a family has paid a total of $11,500 in eligible medical in-network expenses or $33,000 in out-of-network expenses in one calendar year, the plan will pay 100 percent of eligible expenses, up to the maximum allowable charge for the rest of the calendar year.

Emergency room copayments do apply to the out-of-pocket limit. However, you must pay the emergency room copayment for each emergency room visit even after the out-of-pocket limit is met.

Benefits: In-Network or Out-of-Network

In-network benefits are those provided by a network provider. You will pay a percentage of the cost when you receive care. With out-of-network benefits, you can receive care from doctors and hospitals not participating in the network and benefits will be provided, but at a reduced level.

If you utilize an out-of-network provider the cost to you will be substantial. You will receive the lower level of benefits and will be required to pay the difference between the maximum allowable charge (MAC) and the actual charge. Also remember certain services will not be covered out-of-network. Your health care coverage does not allow payment for services you receive in-network or out-of-network which are not medically necessary for your condition. If care given is not found to be appropriate and necessary, then no benefits will be available and you will be liable for the services.

Maximum Allowable Charge Defined

In the simplest terms, the maximum allowable charge (MAC) is the maximum amount that we will pay to a particular provider for a particular service. Providers who have contracted with us to provide network services have agreed to accept that amount as payment in full, writing off the rest of the charge after any applicable deductible, coinsurance, or copayment is paid by the member.

Precious Cargo Prenatal Program

Precious Cargo links mothers-to-be with important pregnancy-related health care information. The choices you make during your pregnancy can help give your baby a healthier start in life. Providing you with important information during the course of your pregnancy, in addition to your doctor's care, gives you the tools needed to make healthy choices.

With Precious Cargo, you are urged to visit your doctor as soon as you think you are pregnant. If you are pregnant, promptly enroll in the program. To be eligible for the program, you must register by your 17th week of pregnancy. Once you are enrolled, a nurse will call you to set up an interview, conducted by phone in the privacy of your home. While this program is an important feature of your health care coverage, it does not take the place of the care given by your doctor. The program helps identify certain health conditions early in the pregnancy.

When you enroll in Precious Cargo, you receive:

- Two confidential pregnancy health assessments
- Helpful prenatal information
- Access to BabyLine, a toll-free, 24-hour information line
- A $50 credit towards your deductible or a check for $50 if your deductible has been met

If you would like to enroll in the program or need more information, call 1-800-395-BABY.

Urgent Care

Members sometimes have a need for medical care during evenings or on weekends. "Urgent care" is care that is important, but does not result from a life-threatening condition. Urgent care health problems are usually marked by rapid onset of persistent or unusual discomfort associated with an illness. If you need urgent care, contact your doctor or specialist. Many physicians' offices use an answering service after hours. When you call after regular hours, be prepared to describe your symptoms and leave a number where the doctor can call you back. Your doctor will offer advice and the best course of treatment for you.

Examples of urgent care situations are:

- Difficulty in breathing
- Prolonged nose bleed
- Short-term high fever
- Cuts requiring stitches

Emergency Care

If you have a medical emergency, seek treatment at the nearest medical facility. Contact your doctor or our member service section within 24 hours if you are in the State of Tennessee or 48 hours if you are out-of-state. Your doctor will make arrangements for your follow-up care.

Use of the Emergency Room

The emergency room (ER) should be used only in the case of an emergency or in an urgent care situation when your doctor advises. The highest level of benefits is available for any emergency room visit that meets the following definition of an emergency. If out-of-network providers are utilized, benefits will be paid based on reasonable charges.

An "emergency" is a medical condition of sudden onset that manifests itself by symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the individual in serious jeopardy (or, with respect to pregnant women, the health of the woman or her unborn child)
- Serious impairment of bodily functions
- Serious dysfunction of any bodily organ or part

The prudent layperson approach is designed to address the issue of the need for a member to seek prompt access to care when symptoms appear serious.

For each covered emergency room visit, you will pay the emergency room copayment unless admitted or if the visit is a follow-up visit for the same episode of care within 48 hours of the initial visit to the emergency room. Should the ER require you to pay in full (not in-network), file the billing statement, along with a claim form, with our office and you will be reimbursed subject to the terms and conditions of the plan.

24/7 Nurseline

You never know when you might get sick or injured. But with your BlueCross BlueShield of Tennessee health plan, a registered nurse is just a phone call away. 24/7 Nurseline is a free service that enables you to speak with a registered nurse any time of day or night – about any type of health condition or just for advice. No matter what the health concern – a cut finger, child's fever, possible food poisoning, skin rash, sprained ankle – an experienced nurse will help you decide what kind of care you need. Whether it's self-care at home or a possible trip

to the doctor, knowing the right kind of care saves time, money and – most of all – worry. Call toll-free 1-866-904-7477 today to speak confidentially with a nurse. Remember, no question is too big or too small.

Hospitalization

If you need to be hospitalized, your doctor will make the necessary arrangements at a network facility. If you are admitted to a hospital (in-network or out-of-network) without our prior authorization, your benefits will be greatly reduced.

If you are out of the network service area or for some reason are unable to reach your doctor before seeking care, you should notify your doctor of any urgent care hospitalization within 24 hours (48 hours if you are out-of-state) of your admission. You should also notify your physician of emergency admissions within the same timeframe. This allows your doctor to make necessary arrangements for any follow-up care. If you have seen a specialist and need to be admitted to a hospital, your specialist will coordinate your hospital care with our office. Maternity admissions do not require pre-authorization.

Out-of-Area "BlueCard" PPO Program

With the BlueCard PPO Program, your standard benefit structure is available nationwide. In order to receive the higher level of benefits outside of Tennessee, you must present your medical ID card to the provider. Your ID card contains a "PPO in a suitcase" logo which identifies you as a member of the BlueCross BlueShield BlueCard PPO program. The BlueCard PPO provider will verify your membership and coverage information. Then, after you receive care, that provider will file your claim electronically. The BlueCard PPO network links together PPO network providers from Blue Plans across the United States. This network is immense and provides access to 95 percent of the U.S. population. In order to locate a BlueCard PPO provider outside of Tennessee, call the number listed in the member service section and a service representative will provide you with names and addresses of participating providers in the requested area.

Just like the PPO program within the State of Tennessee, certain services must have prior authorization. Most providers will handle this for you. However, outside of Tennessee, you should either call to initiate the process or follow up to make sure that it is done. There is no mechanism outside of Tennessee for this plan to require the provider to write off benefit reductions or denials for non-covered experimental or investigational procedures or services that occur as a result of failure to comply with prior authorization requirements. This means you will be responsible for any such reductions or denials.

When you get covered health care services through the BlueCard Program, the amount you pay for covered services is usually calculated on the lower of the:

- Billed charges for your covered services; or
- Negotiated price that the local BlueCross and/or BlueShield Plan ("host plan") passes on to us.

Often, this "negotiated price" will be a simple discount that reflects the actual price the host plan pays. Sometimes, it is an estimated price that takes into account special arrangements with the provider or a provider group that include settlements, withholds, non-claims transactions (such as lost investment income on advance deposits made with providers), and other types of variable payments. Occasionally, it may be an average price, based on a discount that results in expected average savings after taking into account the same special arrangements used to obtain an estimated price. Average prices tend to vary more from actual prices than estimated prices. Negotiated prices may be adjusted going forward to correct for over- or underestimation of past prices. However, the amount you pay is considered a final price.

Laws in a small number of states may require the host plan to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any covered health care services according to the applicable state statute in effect when you received care.

Prior Authorization

Prior authorization is designed to encourage the delivery of medically necessary services in the most appropriate setting, consistent with medical needs of the member and with patterns of care of an established managed care environment for treatment of a particular illness, injury, or medical condition. Prior authorization is required for certain services including, but not limited to:

- Inpatient hospital services
- Skilled nursing facility stays
- Home health care
- Inpatient rehabilitation services
- 23 hour or less observation room stays
- Hospice
- Inpatient cardiac rehabilitation
- Home infusion therapy (certain drugs)
- Private duty nursing

Certain drugs used for home infusion therapy also require prior authorization. All providers for the above services should request these authorizations prior to services being rendered, except in an emergency situation. When a prior authorization is required, but not obtained, benefits will be reduced to 50 percent of medically necessary expenses for out-of-network providers and no benefits will be paid for network providers.

Coordination of Benefits with Other Insurance Plans

If you are covered under two different insurance plans, benefits will be coordinated for reimbursement up to 100 percent of allowable charges. At no time should reimbursement be more than 100 percent of actual expenses. If you are covered as the subscriber or employee by more than one group health program, primary and secondary liability between the plans will be determined based on the order of benefit determination rules included in the Plan Document. Different coordination of benefit rules apply based on the type(s) of policies you may have and the status of those policies (e.g. active, retired, COBRA). If your spouse has coverage through his or her employer, and has you covered, then that coverage would be primary for your spouse and secondary for you. When this medical plan is primary, the benefits of this plan are calculated just as if the other plan did not provide benefits. Primary coverage on children is determined by which parent's birthday comes earliest in the calendar year. The insurance of the parent whose birthday falls last will be considered the secondary plan. The determination of primary or secondary coverage may be altered in the case of divorced parents when a court decree specifically designates the parent whose coverage will be primary. A copy of the court decree should be submitted to our office.

Once a year you will be asked to validate the information on file concerning other coverage. This is done because it is not uncommon for this type of information to change. Periodic validation helps us ensure accurate claims payments. The completed form letter must be received before any further claims processing can take place. You may also update this information on-line using BlueAccess.

Claims Subrogation

The medical plan has the right to subrogate claims. This means that the medical plan can recover (1) any payments made as a result of injury or illness caused by the action or fault of another person, or (2) a lawsuit settlement from payments made by a third-party insurance company. This would include automobile or homeowners insurance, whether yours or another's. You are required to assist in this process and should not settle any claim without written consent from our subrogation department.

Out-of-Country Care

When traveling outside of the United States for business or pleasure, eligible expenses incurred for medically necessary services are covered at the in-network level. No benefits will be paid if a covered person travels to another country for the purpose of seeking medical treatment outside the United States. Claims from a non-English speaking country should be translated to standard English at the covered person's expense. Claim forms should contain valid procedure and diagnosis codes and include the current exchange rate, if available, before being submitted for payment.

Use of BlueCard WorldWide participating providers is encouraged. These providers and facilities provide modest discounts as well as the assurance of BlueCross BlueShield of Tennessee billing through the BlueCard system. If you require services for routine or non-urgent care, be sure and select a BlueCard Worldwide provider or the out-of-network benefit level applies.

Benefit Level Exceptions

Two types of exceptions — unique care and continuous care — may be granted for which benefits will be paid at the in-network level to an out-of-network provider or facility. All requests for exceptions are reviewed individually by our office. *Exceptions will be granted only for medical necessity, not for convenience*. To apply for a unique or continuous care exception, work with your provider to submit the following information in a letter to our office address, attention State of Tennessee Unique Care Coordinator. Within two to three weeks, you will be notified whether your request is granted or denied. If the items listed below are not provided with the initial request, the decision may be delayed until all pertinent information can be gathered.

- Patient name and ID number
- Name and type of provider you are requesting
- Diagnosis and treatment plan, date(s) of service
- A statement explaining why this treatment cannot be received at a network facility or provided by a network physician

Unique Care Exceptions

A unique care exception can be granted for treatment not routinely available from a network provider in an employee's geographic area. This exception is based on the patient's condition or need for a particular physician and must be requested before receiving care. We will determine whether a network provider is available to provide treatment for the illness or injury.

If a unique care exception is granted, benefits are paid at the in-network level. Any charges above the maximum allowable are the patient's responsibility. If distance (out-of-state) traveling is required, reimbursement will be at 80 percent of commercial coach airfare or ground travel at the state approved mileage rate, if appropriate. When unique care exceptions are granted, a time frame for this approval is given. If the need for unique care is anticipated beyond the stated time frame, then another unique care request must be submitted before the time frame is exceeded. Updated medical information documenting the continued need for out-of-network care will be required. The review of this request to extend a unique care approval will include an examination of the available network in an effort to determine if the required care can now be accessed within the network.

Continuous Care Exceptions

A continuous care exception can be granted when a patient is undergoing an active treatment plan for a serious medical condition, including pregnancy. This exception takes into account a patient's established relationship with an out-of-network provider. Our medical director will determine the time frame in which continuous care can be covered. Any charges above the maximum allowable are the patient's responsibility.

Coverage For Second Surgical Opinion Charges

In some instances, you have the option to receive a second surgical opinion. Second surgical opinions are not required. The second surgical opinion must be obtained from a surgeon qualified to perform the surgical procedure, but who is not in the same medical group as the physician who originally recommended surgery.

Charges for the second surgical opinion and any tests performed in obtaining the second surgical opinion will be paid at 100 percent of the maximum allowable charge if a network provider is used.

If you wish to obtain a second surgical opinion about a procedure *not included on the list below*, normal plan benefits and rules apply. Any surgeries (including those listed) must be medically necessary to be approved.

- Bone and joint surgery of the foot
- Cataract extraction with and without implant
- Cholecystectomy
- Hysterectomy
- Knee surgery
- Septoplasty/sub-mucous resection
- Prostatectomy
- Spinal and disc surgery
- Tonsillectomy and adenoidectomy
- Mastectomy
- Elective C-section

Case Management

Case management is a program that promotes quality and cost effective coordination of care for members with complicated medical needs, chronic illnesses, and/or catastrophic illnesses or injuries. Members who need case management are identified and contacted by phone or in writing to discuss or propose alternative treatment plans. Members may also contact member service if they believe they would benefit from case management. In situations involving medical appropriateness, a case manager may approve additional speech, occupational, and physical therapy visits beyond plan limits.

Filing Claims

Our office is responsible for all medical plan claims processing. When you visit a network doctor or facility, be sure and show your identification card. The provider will file your claim directly. These network providers must file your claim within six months of the date of service. All questions regarding claims, including requests for claim forms, should be addressed to member service.

If you visit an out-of-network doctor or facility, you may be responsible for filing claims. Out-of-network providers may also require payment in full at the time of service. The appropriate form must be used and a separate claim form must be completed for each individual who has received services. More than one bill can be submitted on a claim form. For out-of-network providers, you have 13 months from the date of service to file claims and be eligible for reimbursement.

Disease Management Program

Healthy Focus Disease Management includes programs for those with congestive heart failure, coronary artery disease, chronic obstructive pulmonary disease, diabetes and asthma. Registered nurses and health educators provide customized health education and support in self-care methods as well as encourage adherence with physician-directed treatment plans. The Healthy Focus programs are focused on helping each participating individual reach optimal health.

Members are identified as potential Healthy Focus participants through review of medical and pharmacy claims information. If you are identified for one of these programs, you'll be sent an introductory letter, which will be followed by a welcome call. Your primary physician will also be sent a letter advising that you've been offered this opportunity as part of your health plan. During your welcome call, you'll be given an opportunity to ask any questions you might have and you'll be given all the details you need to take full advantage of this opportunity. Once enrolled in Healthy Focus, you'll be offered special mailings and an informative quarterly magazine. A nurse will call you periodically to offer coaching and instruction and support. The frequency of these calls will be suggested based upon the severity of your condition. In addition, you'll be able to call in to speak with your nurse any time you need more information or support. An interactive web site further enhances the educational, coaching and tracking aspects of this program.

Blue Perks

BluePerks Discount Program is a value-added program which provides up to a 30% discount on services provided through participating BluePerks Discount Program practitioners.

The BluePerks Discount Program is not a covered benefit or service like doctor office visits or hospital stays. Members are responsible for the entire cost of all services they receive from participating providers. Services in the BluePerks Discount Program include:

- Acupuncture
- Fitness Center Memberships
- Massage Therapy and Somatic Education
- Nutrition Counseling
- Spas
- Stress Management

For more information about the BluePerks program, visit our website.

Pharmacy Program

Three levels of benefits are available for prescription drugs, and your choice determines the coinsurance amount you pay each time you have your drugs dispensed by a participating network pharmacy.

- Generic drugs are in the first tier and offer the best value. When your doctor writes your prescription, ask about using a generic drug. Generics are safe, effective, and affordable alternatives to brand name drugs, and are available in many instances.
- Preferred brands are in the second tier. If a generic alternative is not available, talk to your doctor about prescribing a brand-name drug from the preferred drug list. This list includes many popular brand-name drugs.
- Non-preferred brands are in the third tier and will cost you the highest coinsurance.

Limitations

Prescriptions may be filled for the quantity specified by your physician for a single course of treatment up to a 34-day supply at retail or, if appropriate, up to a 102-day supply through the home delivery program and certain participating mail-at-retail pharmacies.

Certain drugs may have prior authorization requirements or specific quantity limits. These drugs cannot be dispensed by the pharmacist in an amount greater than the specified limit or where prior authorization has not been obtained by your physician. You should talk to your doctor if you encounter problems with the quantity limits or prior authorization requirements of the pharmacy program.

Exclusions

Some types of medications are not covered by your plan. An exclusion does not mean you cannot have a particular drug; it simply means that no benefits will be provided and you will be responsible for the total cost of the drug.

Filling a Prescription at a Retail Pharmacy

Visit a participating network pharmacy and show your ID card when you purchase your prescription. Pay the appropriate coinsurance for the prescription at that time and your network pharmacist will electronically file your claim. If filling an extended-duration prescription at retail, be sure to use a participating mail-at-retail provider.

If you use a non-network pharmacy, you must pay all costs and file the claim with the claims administrator. Contact member service for the appropriate form. You will be reimbursed based on the maximum allowable charge, less the applicable coinsurance amount. Your cost will also be greater if you utilize a network pharmacy and fail to have the claim filed electronically. All requirements such as quantity limits and prior authorization apply.

If you are planning a trip and need to purchase medications ahead of time, your pharmacist can call 1-800-345-5413 to arrange for up to an additional 34-day supply. If more is needed for an extended trip, call member service before visiting the pharmacy. If you are out of your service area and need to obtain a prescription, you can go to a participating pharmacy in our nationwide chain.

Filling a Prescription Using the Home Delivery Program

To begin using the home delivery program, follow these steps:

- If you currently obtain your prescription at a retail pharmacy and want to begin using the home delivery program, contact FastStart at 1-866-443-9159.
- Let the FastStart operator know you wish to obtain your prescription order through home delivery. Be prepared to give the operator your member ID number from your identification card, name(s) of medication you need, and your shipping address. You will also need to provide a credit card number for your coinsurance and your prescribing physician's name and phone number.
- Caremark will contact your doctor and you will be notified if there are any problems. If authorized, your medication will be mailed to you within 10-14 days from the time your order is placed.

If you prefer, you can send your prescription order via mail following these steps:

- Obtain a written prescription from your doctor for up to a three-month supply of your medication, with three refills, if appropriate.
- Complete a mail order service form. A copy is enclosed in the back of this handbook.
- Send the order form, along with your prescription, to the address at the bottom of the form. Be sure to include your credit card information for your coinsurance or send a personal check. If you have questions about the amount to include, contact the prescription home delivery service line.
- You will receive your medication, along with written information about your medication, within 10-14 days from the time you mail your order.

Once you have started using the benefits of the home delivery service, you can order medication refills at www.caremark.com or by phone at 1-877-683-6837. You will need to provide your prescription number, five-digit zip code and credit card information.

Specialty Pharmacy Program

The Specialty Pharmacy Program gives members with chronic health conditions such as hepatitis C, multiple sclerosis, arthritis and hemophilia, access to specialized drugs. Specialty medications are either provider-administered (given by a health care professional in an office setting) or self-administered (taken by the patient at home).

Self administered medications are available through selected vendors that have expertise in these types of high-cost, specialized medications and have agreed to offer these drugs at discounted rates.

When you order specialty pharmacy medications from these vendors, you get convenient delivery of your self-administered specialty medications and related supplies. You can also take advantage of other services offered by these vendors including access to licensed pharmacists who can answer any questions or concerns you may have about your medication.

You and your doctor may choose from any of the following specialty pharmacy vendors:

- Caremark Specialty Pharmacy Services:
1-866-295- 2779 (phone); 1-866-295-2778 (fax)
- CuraScript Pharmacy/Priority Healthcare:
1-888-773-7376 (phone); 1-888-773-7386 (fax)
- Accredo Health Group:
1-888-239-0725 (phone); 1-866-387-1003 (fax)

To purchase your specialty pharmacy medication from one of these vendors, ask your doctor to fax your written prescription to one of the specialty pharmacies listed above. Medical appropriateness review may be required. The specialty pharmacy will ship your medication directly to your home or other address if appropriate. Due to the fragile nature of these medications, and to ensure drug quality, all shipments are limited to a 34-day supply.

For more information regarding specialty pharmacy drugs and those that require prior authorization or have special medical appropriateness criteria, go to the pharmacy section of our Web site.

Member Rights and Responsibilities

Member Rights

You have the right to:

- Be treated with respect and dignity.
- Expect that any information you give will be treated in a confidential manner.
- Information about policies and services of the plan.
- Information regarding network providers.
- Medically necessary and appropriate medical care.
- Information about your health.
- Make decisions about your health care with practitioners.
- Voice complaints about your health care providers, the care given to you, or the PPO-Limited plan. You can expect an answer within a reasonable time. You also have the right to formally appeal this answer if you do not agree.
- A candid discussion of appropriate or medically necessary care options for your condition, regardless of cost or benefit coverage.

Confidentiality and Privacy

Your health is your own private business. Be assured that we will treat your medical records and claims payment history in a confidential manner. When you enroll in the plan, you give routine consent for certain matters. That allows the company to release information without your prior written consent for these purposes:

- Claim processing.
- Performing peer review, utilization review, and medical audits.
- Administration of programs established by us for quality health care and control of health care costs.
- Medical research and education.

Important steps are taken to protect your privacy.

- Employees have been trained to understand the importance of safeguarding your privacy. In fact, they sign confidentiality agreements to ensure they will carry out the established policies.
- Contracted practitioners and providers follow confidentiality guidelines set forth by the state in which they practice.
- Vendors must sign confidentiality agreements if they receive personal health information for purposes of plan administration such as measurement of data to improve quality.
- It is the policy not to release member-specific health information to employers unless allowed by law.
- Members have the right to approve the release of personal health information in special circumstances beyond those listed above.

Members can take comfort in knowing that confidentiality is important. You are encouraged to call one of the member service representatives if you have questions about privacy policies and practices.

Women's Health and Cancer Rights Act

Your medical plan's coverage of a medically necessary mastectomy also includes post-mastectomy coverage for reconstruction of the breast, surgery on the other breast to achieve the appearance of symmetry, prostheses, and physical complications during any stage of the mastectomy, including lymphedemas. This coverage will be provided in consultation with the attending physician and patient. Benefits are subject to the same annual deductibles and coinsurances as other services and pre-existing waiting periods apply, if applicable.

Member Responsibilities

Members are responsible for:

- Reading the member materials in their entirety and complying with the rules and limitations as stated.
- Contacting in-network providers to arrange for medical appointments as necessary.
- Notifying in-network providers in a timely manner of any cancellations of appointments.
- Paying the coinsurance and deductibles as stated in the benefit plan documents at the time service is provided.
- Receiving a pre-authorized referral for services, when required, and complying with the limits of the pre-authorized referral.
- Carrying and using their plan identification card and identifying themselves as a plan member prior to receiving medical services.
- Using in-network providers consistent with the applicable benefit plan.
- Providing, to the extent possible, information needed by professional staff in order to care for the member.
- Following instructions and guidelines given by those providing health care services.

Appeal Procedures

If you experience a problem relating to the plan policies or the services provided, there are established procedures to help you resolve your complaint. These procedures do not apply to any complaint or grievance alleging possible professional liability, commonly known as malpractice, or for any complaint or grievance concerning benefits provided by any other plan.

Administrative Appeal

To file an appeal regarding an administrative process or decision (e.g., transferring between health plans, effective dates of coverage issues, or timely filing issues) contact your agency or workplace insurance preparer immediately.

Mental Health and Substance Abuse Appeals

Contact Magellan Health Services at 1-800-308-4934 for EAP, mental health and substance abuse appeals.

Appealing to the Claims Administrator

If you are in disagreement with a decision or the way a claim has been paid or processed, you or your authorized representative should first call member services to discuss the issue. If the issue cannot be resolved through member services, you may file a formal request for review or member grievance by completing the appropriate form and returning it within the specified time frame. When your completed form is received, you will get an acknowledgement letter advising you what to expect regarding the processing of your grievance. When a determination is made, you will be notified in writing and advised of any further appeal options.

If a denial of coverage or authorization can reasonably be expected to prevent a covered individual from obtaining urgently needed covered services (e.g., because the member cannot afford to pay for such services), then providers may request an expedited reconsideration. If the treating provider or primary care physician fails to request the reconsideration and decides not to provide urgently needed services, then the member, or someone acting on the member's behalf, may request the expedited reconsideration. If we agree that it is appropriate to conduct an expedited reconsideration, we will inform the member of our decision as quickly as possible based on the circumstances of the care, including the ability to obtain information concerning the case from the provider.

Please Note: The expedited reconsideration process is only applicable in situations where a benefit determination or a preauthorization denial has been made prior to services being received.

Appealing to the Plan Administrator

The State of Tennessee, Division of Insurance Administration has an appeal process that is available to you AFTER you have exhausted the grievance process with the claims administrator. Appeals must be requested in writing within two years of the claim determination or decision. To file an appeal at the state level, the member should send a letter and supporting documentation (e.g., explanation of benefit statements, decision letters, statements from healthcare providers, and medical records) to:

Appeals Coordinator, Division of Insurance Administration
13th Floor, Wm. R. Snodgrass Tennessee Tower
312 Eighth Avenue North
Nashville, TN 37243

It is a good idea to maintain a copy of all correspondence you send. Specific questions regarding the appeal process may be directed to the appeals coordinator at 615-741-3590 or 1-800-253-9981.

The appeals coordinator in the Division of Insurance Administration will thoroughly review all information submitted to determine the exact nature of the appeal. The majority of requests for appeal require additional review by the claims administrator. The average review takes approximately 60 days to complete. Some cases may require additional time for review depending on individual circumstances. Some cases may also require review by the state's independent medical consultant.

If consideration of your appeal does not result in a satisfactory resolution, the appeals coordinator may schedule it for additional review by the Insurance Appeals Staff Review Committee. When this occurs, the member will have the option of attending the committee meeting, or the appeal can be reviewed based on the written record. The Staff Review Committee will hear the appeal and their recommendation will be reported to the Appeals Subcommittee. The subcommittee will respond to the appeals coordinator within two weeks to indicate whether they agree with the Staff Review Committee's recommendation or vote to review the appeal at a second meeting. If the subcommittee agrees with the recommendation of the Staff Review Committee, the decision will stand. Members will be notified in writing as to whether or not requests are approved or denied by the committee. For denial decisions, the notification letter will explain any additional appeal options.

Q&A

Q Is my child who is attending college out of state covered at the network level?

A Children attending college out of the service area should utilize the BlueCard PPO program when receiving medical services. The BlueCard PPO program links together PPO network providers from Blue Plans across the United States. Please refer to the BlueCard PPO section of this handbook for specific information.

Q Other than the benefit level, are there other differences if I use out-of-network providers?

A Out-of-network providers can bill you for any difference between actual charges and the approved amount plus any services deemed not medically necessary or not authorized. When you use a out-of-network provider, the charges for which you are responsible may be substantial.

Q Do I have a choice of hospitals?

A We have contracted with certain hospitals to provide care to you. If specialty care is not available at the contracted hospital(s), arrangements will be made to the appropriate non-network hospital.

Q What happens if my doctor disagrees with a medical policy regarding my covered treatment alternatives?

A A provider appeals process is available for this situation.

Q How are the lists of prescriptions requiring prior approval and prescriptions with quantity limitations determined and how can they be changed?

A These lists are developed and maintained by a committee. The lists are established annually and reviewed quarterly and contain medications that are clinically effective as well as cost effective. A member or provider may suggest changes to these lists by contacting our office. Suggestions will receive a written response.

Q What if my physician is out of the office?

A Physicians “cover” for each other on a rotating schedule. This means there may be times when you will not be able to speak with your physician. The nurse or physician on call will be able to help you.

Q What if I must reach my physician after regular office hours?

A Most physician offices utilize an answering service; therefore, when you call after regular office hours, you will most likely talk to a representative from the answering service. The on-call health care professional will request some identifying information and will need a general description of your urgent medical need.

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